

FILED OCT 21 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34591

State File No. \_\_\_\_\_

Registrar's No. 281

BIRTH NO. _____		REG. DIST. NO. 200		PRIMARY REG. DIST. NO. 4316		Registrar's No. 281		
1. PLACE OF DEATH a. COUNTY <u>Macon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before death) STATE <u>Missouri</u> COUNTY <u>Macon</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>New Cambria</u>		c. LENGTH OF STAY (in this place) <u>16 mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>New Cambria</u>		0610		
d. FULL NAME OF HOSPITAL OR INSTITUTION -----				d. STREET ADDRESS (If rural, give location) -----				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Vivian</u>			b. (Middle) <u>Deloss</u>			c. (Last) <u>Stephenson</u>		
4. DATE OF DEATH (Month) (Day) (Year) <u>Sep. 25, 1954</u>								
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Oct. 13, 1902</u>		9. AGE (In years last birthday) <u>51</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>12</u>	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming-Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Lingo twp., Macon Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13a. FATHER'S NAME <u>Dillard Stephenson</u>			13b. MOTHER'S MAIDEN NAME <u>Bessie Edith Babbitt</u>			14. NAME OF HUSBAND OR WIFE <u>Merelean Stephenson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>No.</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Merelean Stephenson, New Cambria</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
19a. DATE OF OPERATION <u>      </u>		19b. MAJOR FINDINGS OF OPERATION <u>      </u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>      </u> <u>      </u> <u>      </u>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>      </u>				
22. I hereby certify that I attended the deceased from <u>Sept 22, 1954, to Sept 25, 1954</u> , that I last saw the deceased alive on <u>Sept 25, 1954</u> , and that death occurred at <u>9-30 p.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>R. Cowest</u>					23b. ADDRESS <u>M. D. New Park, Mo. 64505</u>		23c. DATE SIGNED <u>      </u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sep. 28, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>New Cambria Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>New Cambria, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>10/2/54</u>		REGISTRAR'S SIGNATURE <u>Ruth McNeely</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. J. Hilliard</u>		ADDRESS <u>New Cambria Mo.</u>		

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

No. 300

10-48

RECEIVED 10.19.54  
MACON COUNTY HEALTH DEPARTMENT  
County File No. 10.54.159  
Date Filed 10.19.54

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed H. J. Gilleland

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 4019

P. O. Address New Cambria Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.